WYOMING WORKERS' SAFETY AND COMPENSATION
PREAUTHORIZATION CHECK SHEET
ROTATOR CUFF REPAIR
SHOULDER

Claimant: _____ Case Number: _____ DOI: _____
Surgeon: _____ Phone Number: _____ Contact: _____
Date of Review: _____ Reviewer: _____
Compensability should NOT be in question at the time of preauthorization for this procedure.

I. Conservative Care:

Acute case:

a. Anti inflammatories. ☐ Yes ☐ No
b. Rest. ☐ Yes ☐ No
c. Failure to improve with conservative care in 1 to 3 weeks or longer. ☐ Yes ☐ No

II. Clinical Findings:

Subjective

a. Shoulder pain. ☐ Yes ☐ No

Objective

a. May or may not have a weak or absent abduction, and/or ☐ Yes ☐ No
b. Tenderness over rotator cuff, and/or ☐ Yes ☐ No
c. Pain relief obtained with an injection of anesthetic for diagnostic/therapeutic trial. ☐ Yes ☐ No

Imaging

a. Positive findings on arthrogram. ☐ Yes ☐ No
b. Positive findings on MRI. ☐ Yes ☐ No
c. Positive findings on ultrasound. OR ☐ Yes ☐ No
d. Positive findings on previous arthroscopy, if performed. ☐ Yes ☐ No

Approved/Nurse name: _____ Date: _____
Sent for Peer review/Doctor: _____ Date: _____
Notes: _____
_____